FORT WORTH
COUNSELING & INTERVENTION

Intake Questionnaire:

Date: _____

Client Name: _____

Street Address: _____ City: _____ State: _____ZIP: _____

Date of Birth: _____ Gender: ____

Home Phone: _____ OK to leave message? __ Yes __No

Office Phone: _____ OK to leave message? __ Yes __No

Mobile Phone: _____ OK to leave message? __ Yes __No

OK to use text messaging? __ Yes __No

E-mail address: _____

OK to use e-mail for messages? __ Yes __No

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1. What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

2. What are your goals for counseling?

3. Have you seen a mental health professional before? Please specify dates, reason for counseling and your experience.

4. Specify all medications and supplements you are presently taking and for what reason.

5. If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

6. Who is your primary care physician? Please include type of MD, name and phone number.

7. Do you drink alcohol? Describe type, amount, and frequency.

8. Do you use recreational drugs? Describe type, amount, and frequency.

9. Do you have suicidal thoughts? Please describe.

10. Have you ever attempted suicide? Please describe.

11. Do you have thoughts or urges to harm others? Please describe.

12. Have you ever been hospitalized for a psychiatric issue? Please describe, where, when and why?

13. Is there a history of mental illness in your family? Please describe.

14. Do you have any current or previous legal issues or investigations, such as driving under the influence, court-ordered treatment, conviction of a crime, civil lawsuits, etc.?

15. If you are in a relationship, please describe the nature of the relationship and months or years together.

16. Please briefly describe the nature of any significant previous relationships, and the months or years together.

17. Describe your current living situation. Do you live alone, with others, with family, etc?

18. What is your level of education? Highest grade/degree and type of degree.

19. What is your current occupation? What do you do? How long have you been doing it?

20. Do you have a religious preference?

21. How much influence does spirituality have in your day-to-day living?

1	2	3	4	5	6	7	8	9	10

Not at all Very much

22. Please circle any of the following you have experienced in the past six months:
    1. Increased appetite
    2. Decreased appetite
    3. Trouble concentrating
    4. Difficulty sleeping
    5. Excessive sleep
    6. Low motivation
    7. Isolation from others
    8. Fatigue/low energy
    9. Low self-esteem
    10. Depressed mood
    11. Tearful or crying spells
    12. Anxiety
    13. Fear
    14. Hopelessness
    15. Panic
    16. Other: _____

23. Please circle any of the following that apply:
    1. Headache
    2. High Blood Pressure
    3. Gastritis or esophagitis
    4. Hormone-related problems
    5. Head Injury
    6. Angina or chest pain
    7. Irritable Bowel
    8. Chronic Pain
    9. Loss of consciousness
    10. Heart attack
    11. Bone or joint problems
    12. Seizures
    13. Kidney-related issues
    14. Chronic fatigue
    15. Dizziness
    16. Faintness
    17. Heart valve problems
    18. Urinary tract problems
    19. Fibromyalgia
    20. Numbness & tingling
    21. Shortness of breath
    22. Diabetes
    23. Hepatitis
    24. Asthma
    25. Arthritis
    26. Thyroid issues
    27. HIV/AIDS
    28. Cancer
    29. Other: _____

24. What else would you like me to know?

25. Who referred you?

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT:

_____
Name of Client:

_____
Signature of Client or Guardian if Client is under 18 years of age:

Kimberly Knox, LMFT-Associate
Fort Worth Counseling and Intervention
kknox@fwcai.com
817-647-1157
www.fwcai.com
www.kimknox.org

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. **MY PLEDGE REGARDING HEALTH INFORMATION:** I understand that health information about you and your health care is personal. I am committed to protecting your health information. I will create a record of the care and services you receive from me after each session. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this counseling practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request in my office and on my website.

II. **HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:** The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

- <u>For Treatment Payment, or Health Care Operations</u>: Federal privacy rules and regulations allow health care providers who have a direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

  Disclosures for treatment purposes are not limited to the minimum necessary standard because therapists and other health care providers need access to the full record and/or

full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a client for health care from one health care provider to another.

- Lawsuits and Disputes: If you are involved in a lawsuit, I may be required to disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request and to allow you to try to obtain an order protecting the information requested. If I am called to testify in court or by deposition, there is a minimum charge for five hours at my normal hourly rate for preparation, travel, and the appearance in court or at deposition. If my time exceeds five hours, you will be charged for the actual time spent.

- Uses and Disclosures that require your authorization: Psychotherapy Notes. I keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

    a. For my use in treating you.
    b. For my use in defending myself in legal proceedings instituted by you.
    c. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    d. Required by law and the use or disclosure is limited to the requirements of such law.
    e. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    f. Required by a coroner who is performing duties authorized by law.
    g. Required to help avert a serious threat to the health and safety of others.

- Marketing Purposes: As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

- Sale of PHI: As a psychotherapist, I will not sell your PHI.

- Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

    a. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
    b. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

c. For health oversight activities, including audits and investigations.
d. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
e. For law enforcement purposes, including reporting crimes occurring on my premises.
f. To coroners or medical examiners, when such individuals are performing duties authorized by law.
g. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
h. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

III. **CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, only if you authorize such disclosure in writing. The opportunity to consent may be obtained retroactively in emergency situations.

IV. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

- The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

- The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

- The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail or e-mail to a different address, and I will agree to all reasonable requests.

- The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.

- The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.

- The Right to Correct or Update Your PHI. If you believe there is a mistake in your PHI, or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

- The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail.

V. **EFFECTIVE DATE OF THIS NOTICE:** This notice went into effect on March 14, 2016.

VI. **ACKOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT:

_____

Name of Client:

_____

Signature of Client or Guardian if Client is under 18 years of age:

Kimberly Knox, LMFT-Associate
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INFORMED CONSENT FOR PSYCHOTHERAPY

I. **GENERAL INFORMATION:** The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

a. Risks and Benefits of Psychotherapy: Most clients seeking counseling are experiencing physiological, psychological, and spiritual issues that are causing internal distress and problems individually and in relationships. The goal of counseling is to reduce the distress associated with these issues and to help clients enjoy a better quality of life. Some individuals may not experience relief and may experience an exacerbation of issues or new and different issues during counseling. If this happens a recommendation will be made for different or more intensive treatment.

Clients in counseling can benefit from the support of family, friends, and a vibrant spiritual community. Clients may also benefit from other types of modalities, such as experiential treatment methods and outside support groups, such as 12-step groups. Where these modalities are not available from Fort Worth Counseling and Intervention, referrals to appropriate providers can be made.

II. **SERVICES OFFERED:** We offer the following counseling services: Pastoral, Individual, Group, Pre-marital, Marital, and Family Counseling from a wide range of theoretical orientations (Cognitive behavioral, psychodynamic, etc.). The counselor and the client(s) will mutually decide which specific form of counseling and particular theoretical orientation is best suited for each person as needs are assessed throughout the course of counseling. Referrals will be made if an expert in an area in which our counselors are not proficient would best serve you.

III. **MEDICAL ISSUES:** I am not a medical doctor and I am not licensed to recognize or diagnose medical conditions. It is our advice that you seek a medical examination to determine whether any of your symptoms are as a result of a physical rather than psychological or spiritual origin. I am also not a psychiatrist, and I cannot prescribe psychiatric medications. You will be referred to a psychiatrist for a consultation if it appears that medications may be helpful.

IV. **PROFESSIONAL RECORDS:** The law and ethical codes require that records of treatment be kept. You are entitled to a copy of these records unless it is believed that you would be emotionally damaged by seeing them, in which case they will be sent to the counselor of your choice to review them with you. These records are kept in a locked cabinet behind a locked door or are encrypted and stored electronically with password protection.

V. **CONFIDENTIALITY:** All communication is confidential and your permission is necessary to release any information to outside persons except for limitations required by the laws of the state of Texas. Exceptions to confidentiality include (a) reasonable suspicion of incidents of child abuse or neglect; (b) incidents of elder abuse, neglect, or exploitation; (c) a determination that you are a danger to yourself or others; (d) a request from you in writing, directing me to deliver confidential information to a specified individual or agency; or (e) I am ordered by a court to disclose confidential information.

In addition, with your permission your information may be shared with other clinicians if to do so will enhance your treatment and my professional expertise. This includes: collaborating and consulting with associates within this counseling group, all of whom agree to maintain confidentiality of your information solely within the group; engaging in supervision with a qualified supervisor for purposes of improving my clinical expertise, in which case the supervisor will have access to your information but is bound by the same confidentiality laws as I am; or in the event I am unavailable and another professional is providing emergency care for my clients, in which case this professional may require access to client files.

VI. **BOUNDARIES:** In order to get the most out of counseling, the therapeutic relationship between client and counselor is of utmost importance. Our goal is to make that relationship as efficacious as possible by keeping that relationship primary and not confusing it with other relationships. In non-therapeutic settings such as at restaurants, shopping, churches or other social settings, I will not be able to discuss counseling issues with you. I want to make sure you understand that I am not trying to be rude when I do not initiate a conversation outside the office; I am just complying with the ethical rules that bind our profession. As social media has become more popular, you should also know that I cannot accept requests to connect via any of the social media platforms with any current clients.

VII. **FEES:** An individual counseling session is 50 minutes. The fee per session is $120.00. You may cancel an appointment more than 24 hours before the scheduled time. If an appointment is cancelled less than 24 hours before the appointment, or you do not show up for the appointment, you will be charged the full session rate unless that time slot can be filled by another client, although I cannot assume an obligation to fill the slot. Group counseling sessions are 90 minutes. The fee per session is $60 payable one month at a time. Credit and debit cards will be charged after each session. Checks and cash must be paid for the month in advance. Absences will not be charged if you notify me before the beginning of the month.

I do not work with insurance companies, therefore all sessions will be out of pocket pay per client.

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_____

Name of Client:

_____

Signature of Client or Guardian if Client is under 18 years of age:

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FORT WORTH COUNSELING AND INTERVENTION PRACTICE POLICIES

I. **APPOINTMENTS AND CANCELLATIONS:** The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session should be discussed with the therapist in order for time to be scheduled in advance.

If you know you are going to miss an appointment, please remember to cancel and reschedule the appointment more than 24 hours in advance. **Cancellations will be subject to the full session fee if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE**. This is necessary because a time commitment is made to you and that time is held exclusively for you. If you are late for a session, you may lose some of your session time.

II. **PAYMENT**: We accept payment by cash, check, debit and most major credit cards, including American Express and Discover. Payment is expected at the conclusion of each session. We will keep an electronic record of a debit or credit card in a secure electronic file for mutual convenience. The form is attached. We ask each client to complete this form for our file, although you are free to pay by other means after a session. A $20.00 service charge will be charged for any checks returned for any reason.

III. **TELEPHONE ACCESSIBILITY:** If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911.

IV. **SOCIAL MEDIA AND TELECOMMUNICATION:** Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

V. **ELECTRONIC COMMUNICATION**: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, fax machines, and e-mail is considered telemedicine. Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you should understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

(2) All existing confidentiality protections are equally applicable.

(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

(6) Effective therapy is often facilitated when the therapist gathers a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make these visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

VI. **MINORS:** If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

VII. **TERMINATION:** Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT:

_____

Name of Client:

_____

Signature of Client or Guardian if Client is under 18 years of age:

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FORT WORTH
COUNSELING & INTERVENTION

CREDIT CARD INFORMATION

A credit card is acceptable payment, and will be used for payment if you either desire to make it the primary payment method, or if you leave the office without paying by some other method. We request credit card information at the outset of counseling, but you are free to pay by other means after any individual session.

To ensure payment, please complete the following:

Credit card number:

_____

Expiration Month _____ Year _____ Security Code _____

Billing address:

Street: _____

City _____ State _____ Zip _____

Name as it appears on the card:

_____

By signing below you are indicating that you have read and agree to the Fort Worth Counseling and Intervention Practice Policies with regard to payment and that you authorize Fort Worth Counseling and Intervention to charge this card for session fees unless you pay for a session by other means:

_____ _____

Client's Signature Date